TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Samuel Z. Moya, D.C.

Respondent Name
Harris County

MFDR Tracking Number
M4-16-2580-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
April 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On April 20, 2016, Requestor faxed an alleged 'second submission-request for reconsideration' dated April 2, 2016; however, this was the first submission of the bill in question received by Respondent."

Response Submitted by: Thornton, Biechlin, Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 2, 2015	Designated Doctor Examination	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Does a dispute exist for the services in question?

Findings

The requestor is seeking reimbursement of $650.00 for a designated doctor examination performed on May 2, 2015. 28 Texas Administrative Code §133.307(c)(2) requires that requests for medical fee dispute resolution from a health care provider include:

(J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);

(K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;

Review of the submitted documentation supports that the initial medical bill was submitted to the insurance carrier on April 20, 2016. The request for medical fee dispute was received by the division on April 26, 2016. The division finds that the requestor has not met the requirements of 28 Texas Administrative Code §133.307. Therefore, no medical fee dispute exists for the services in question.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	May 20, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.